ARIZONA STATE VETERAN HOME – PHYSICIAN'S STATEMENT

The following is to be completed and signed by the applicant's physician

1. Name of Applicant:_____
2. Date of Birth:_____
3. Is this person capable of caring for him/herself? _____ YES _____NO
4. Applicant's current diagnoses:

   _____

   _____

   _____

   _____

   _____

5. Applicant's current medications:

Medication	Dose	Frequency (x per day)

6. Are special treatments or therapies required for this person? _____Yes _____No
If yes, please explain:_____

_____

_____

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7. Could this person be considered a danger to self or to others? _____Yes _____No

8. Have they had a Mantoux TB skin test done in the past 3 months? _____Yes _____No
If yes, please attach copy of the results.

9. Has this person had Pneumovax 23? _____Yes _____No Date:_____

10. Has this person had Pneumovax 14? _____Yes _____No Date:_____

11. If this person is admitted to the Arizona State Veteran Home will you be the attending physician? _____ Yes _____ No

12. Please PRINT the following:

Physician's Name:_____

Street Address:_____

City/State/Zip Code:_____

Telephone Number:_____

Physician's Signature Date